MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92b 06857

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Round Bay, P.O. Severna Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years.
Hospital, Institution, or street address where death occurred:
Luna Lane
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Anne Arundel Co.
City or town: Round Bay, Severna Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Luna Lane
(If rural, give LOCATION)
2.(a) If veteran, name war: World War #1

3.(a) FULL NAME: Mr. Elmer John Ahlhauser

3.(b) Social Security Number: 179-01-2030

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Married.

6.(b) Name of husband or wife: Dorothy Hambleton Ahlhauser
6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): June 28-1899

8. AGE: Years: 49 | Months: 0 | Days: 14 | If less than one day: ....hrs. ....min.

9. Birthplace: Milwaukee, Wisconsin (Town, county, and state)

10. Usual occupation: Sales-Engineer.

11. Industry or business

FATHER
12. Name: Henry Ahlhauser
13. Birthplace: New York City, N.Y.

MOTHER
14. Maiden name: Elizabeth Hattig
15. Birthplace: Germany

16. Informant: Mrs. Dorothy Ahlhauser (wife)
Address: Round Bay, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7/10/48 (month) (day) (year)
Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Baltimore, Md.

19. July 9 1948 (Date rec'd by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7 1948 at 9 A. M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1947 to July 6 1948 and that I last saw him alive on 7/6/48 1948

Immediate cause of death	DURATION
Aortic Stenosis	1 yr
Due to Mitral Insufficiency	"
Due to Hypertension	"
Other conditions Cardiac Decompensation	"

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Gustave A. Faubert M.D. M. D. or other
Address: Glen Burnie, Md. Date signed: 7/7/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932 06858

CERTIFICATE OF DEATH

Reg. Diat. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Glen Burnie (suburb)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(If newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Jones Road (Rural)
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Thomas Elmer Allsup

3.(b) Social Security Number: 218-22-6173

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	married

6.(b) Name of husband or wife: Daisy Allsup
6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): May 1, 1901

8. AGE: Years	Months	Days	If less than one day
47	2	10	hrs. min.

9. Birthplace: Brooks Calvert County Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Pat Allsup
13. Birthplace: Calvert County Maryland

MOTHER
14. Maiden name: Jennie Rice
15. Birthplace: Calvert Cunty Maryland

16. Informant: Daisy Allsup
Address: Jones Road Church

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 15 1948 (month) (day) (year)
Cemetery or crematory: Mount Auburn Cemetery
Location: Baltimore City Maryland

18. Funeral director: Joseph A. Fyeth
Address: 66 West Barnet Baltimore 201

19. 7/13/48 (Date rec'd by registrar) RSW Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11 1948, at 4 10 P M

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post mortem Examination 19 ~~and that I last saw him alive on~~ July 11 1948

Immediate cause of death	DURATION
Acute Dilatation of Heart	Sudden
Due to: Chronic Myocarditis	in town
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Claff M.D. Deputy Medical Examiner
M. D. or Other
Address: Annapolis Md. Date signed: 7-14-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

06859

CERTIFICATE OF DEATH

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Fort George G Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 hr 31 minutes

Hospital, institution, or street address where death occurred:
Station Hospital

How long in hospital or institution? 1 hr 31 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Balto

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2223 Rockwell Ave
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME

ELIZABETH ANN BEACH ~~BABY GIRL~~

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	--

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 17 JULY 1948 0844 hrs.

8. AGE: Years	Months	Days	If less than one day
			1 hrs. 31 min.

9. Birthplace: Fort Geo G Meade, Anne Arundel, Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Gordon Leroy Beach
13. Birthplace: Wisconsin

MOTHER
14. Maiden name: Else Styri[illegible]
15. Birthplace: Norway

16. Informant: Lt Col Gordon L Beach
Address: Ft Geo G Meade, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 19 July 48 (month) (day) (year)

Cemetery or crematory: Post Cemetery

Location: Fort George G Meade, Maryland

18. Funeral director: Lilly & Zeiler, Inc
Address: Eastern Ave, Balto, Maryland.

19. 19 July (Date rec'd by registrar) 19 48 James N. Goerger, Capt., MSC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 July 19 48 at 10 15 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 0844 17 July 19 48, to 1015 hrs 17 Jul 48

and that I last saw h[illegible] alive on 19

Immediate cause of death	DURATION
Premature Birth	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. M. Foster Capt MSC
HENRY M. FOSTER, Capt., M.C., U.S.A. or other

Address: Ft Geo G Meade, Md Date signed: 17 July 48

RECEIVED
JUL 20 1948
BUREAU V. S.

Dr Linhardt.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

C6860

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 hrs

Hospital, institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution? 6 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Eastport,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 406 Adams St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

MINNETA SARAH ELIZABETH BEAVIN

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Everett E. Beavin

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Feb. 18, 1875

8. AGE: Years: 73 Months: 5 Days: 6 If less than one day: ____ hrs. ____ min.

9. Birthplace: Prince George County, Maryland
(Town, county, and state)

10. Usual occupation: Home wife

11. Industry or business

FATHER
12. Name: Henry Thomas ~~Coett~~ Scott.
13. Birthplace: unknown

MOTHER
14. Maiden name: Sarah Yost
15. Birthplace: unknown.

16. Informant: Mr Everett Beavin Sr.
Address: Linthicum Heights, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 27, 48 (month) (day) (year)

Cemetery or crematory: Cedar Bluff Cemetery

Location: Annapolis, Maryland

18. Funeral director: Ben L. Hopping and Son

Address: 170-172 West St. Annapolis, Maryland

19. July 27 19 48 (Date rec'd by registrar) W Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 24 19 48, at 10:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24 19 48 to July 24 19 48 and that I last saw her alive on 10:55 A.M. 7/24 19 48.

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Hypertension C.V. Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Eastport Md Date signed 7/24/48.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

VS A15 9-45-15

RECEIVED
JUL 28 1948
BUREAU V. S.

Claffy

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d C6861

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

I

1. PLACE OF DEATH:
County: A. A.
City or town: Eastport (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: A A
City or town: Eastport (If outside city or town limits, write RURAL and give nearest town)
Street No.: Boucher Pt. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Leo F. Bell
3. (b) Social Security Number

4. Sex: M.
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Mary E. Bell
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Oct 19th 1879
8. AGE: Years 68 Months 8 Days 27 If less than one day ... hrs. ... min.
9. Birthplace: Pri Geo. Co. Md (Town, county, and state)
10. Usual occupation: Ret painter at
11. Industry or business: U.S. Naval Academy
FATHER 12. Name: George W. Bell
13. Birthplace: Pri Geo Co. Md
MOTHER 14. Maiden name: Virginia Scott
15. Birthplace: Pri Geo Co. Md
16. Informant: Mrs Fred Smith
Address: Arnold A. A. Co. Md.
17. Burial (Burial, cremation, or removal, Which?) Date thereof: July 18th 1948 (month) (day) (year)
Cemetery or crematory: Asbury
Location: Arnold Md.
18. Funeral director: John M. Taylor Son
Address: Annapolis Md.
19. July 18 1948 (Date rec'd by registrar) Wm. T. Brund Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15 1948, at 10 20 P. M.
21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Postmortem Examination 19...
~~and that I last saw h... alive on~~ July 15 1948

Immediate cause of death	DURATION
Acute Dilatation Heart	Sudden
Due to: Chronic Myocarditis	6 years
Due to:	

Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner M. D. or other
Address: Annapolis Md Date signed 7/16/48

RECEIVED
JUL 20 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

51c

06862

Reg. Diat. No. 22

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Jessop (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Champion Forest.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County: Anne Arundel

City or town: Jessop (If outside city or town limits, write RURAL and give nearest town)

Street No.: Champion Forest. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MARK D. BOLLES.

3.(b) Social Security Number

4. Sex: M

5. Color or race: W.

6.(a) Single, married, widowed, or divorced: MARRIED

6.(b) Name of husband or wife: FERN J. BOLLES.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): AUG 8, 1908

8. AGE: Years: 39 Months: 10 Days: 28 If less than one day ..... hrs. ..... min.

9. Birthplace: FORT DICKSON, N.Y. (Town, county, and state)

10. Usual occupation: GOV'T CLERK

11. Industry or business: SOC SEC: RECORD DIVISION.

FATHER 12. Name: SCOTT FORD BOLLES.

FATHER 13. Birthplace

MOTHER 14. Maiden name: ELLEN PERIGO.

MOTHER 15. Birthplace: PENNA.

16. Informant: MRS FERN J. BOLLES.

Address: CHAMPION FOREST, JESSOP, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof JULY 9 1948 (month) (day) (year)

Cemetery or crematory: MEADOWRIDGE MEMORIAL GDNS.

Location: BALTO-WASH BLVD AT DORSEY RD.

18. Funeral director: Arthur Shipley.

Address: 505 Washington Blvd, Laurel Md

19. July 6 1948 (Date rec'd by registrar) Clara Kasleigh Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JULY 6 1948 at 11 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1945 to July 6 1948

and that I last saw him alive on ..... 19.....

Immediate cause of death: Adrenal Carcinomatosis —

DURATION: 6 mos.

Due to: Seminoma, probably testicular origin

DURATION: 3 yrs.

Due to:

Other conditions: ✓

(Include pregnancy within 3 months of death)

Major findings of operations: see above

Date of op.

Autopsy results: None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Frank S. Shipley, M.D.

M.D. or other

Address Savage, Md. Date signed 7/6/48

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

JUL 27 1948

JUL 27 1948

RECEIVED
JUL 28 1948
BUREAU V. S.

Dr Purvis

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

06863

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 84 Conduit

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Myers T. Bowlen

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elizabeth C. Bowlen

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): January 13th 1853

8. AGE: Years 95 Months 6 Days 13 If less than one day ..... hrs. ..... min.

9. Birthplace: Annapolis Md (Town, county, and state)

10. Usual occupation: R.R. Bridge Layer and Clerk

11. Industry or business:

FATHER 12. Name: Joseph Bowlen

13. Birthplace: Unknown

MOTHER 14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Mrs John F. Murphy

Address: 84 Conduit St. Annapolis Md.

17. Burial (Burial, cremation, or removal. What?) Date thereof July 24 1948 (month) (day) (year)

Cemetery or crematory: St Anns

Location: Annapolis Md.

18. Funeral director: John W. Taylor Sr. Son

Address: Annapolis Md.

19. July 22 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21st 1948, at 5:15a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 10 1948, to July 21 1948 and that I last saw h.. alive on July 20 1948

	DURATION
Immediate cause of death: Uraemia	48 hrs
Due to: Arteriosclerosis	several yrs.
Due to: & Cr. Nephritis.	Many yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H. Oliver Purvis M. D. or other

Address: Annapolis Md. Date signed: July 21/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15 9-45-15M

RECEIVED
JUL 23 1948
BUREAU V. S.

Dr Bovil

06864

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs

Hospital, institution, or street address where death occurred:

902 Bay Ridge Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 902 Bay Ridge Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

PASQUALE BOVE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lucia Bove

6.(c) If alive, give age: 91 years

7. Birth date of deceased (mo., day, yr.): April 11, 1868

8. AGE: Years	Months	Days	If less than one day
80	3	21	...hrs. ...min.

9. Birthplace: Italy (Town, county, and state)

10. Usual occupation: Ret.

11. Industry or business: Shoemaker

FATHER 12. Name: Carmen Bove

13. Birthplace: Italy

MOTHER 14. Maiden name: Thereasa Marinaro

15. Birthplace: Italy

16. Informant: Mr. Charles Bove

Address: Eastport Post Office, Eastport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-2-48 (month) (day) (year)

Cemetery or crematory: St Mary's Cemetery

Location: Annapolis, Maryland

18. Funeral director: Ben L. Hopping and Son

Address: 170-172 West St. Annapolis Md

19. August 2 19 48 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 19 48 at 9 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28 19 48 to July 31 19 48 and that I last saw h... alive on July 31 19 48

Immediate cause of death	DURATION
Coronal Thrombosis	3 days
Due to Arteri Sclerosis	Several years
Due to	
Other conditions Hypertension	Several years

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ... Injured at work?

23. SIGNATURE: Geo C. Boyd M. D. or other

Address: Annapolis Md Date signed 8-2-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

I

T

RECEIVED
AUG 3 1948
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

50

06865

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: 36 South Street
How long in hospital or institution? ———

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 36 South Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ———

3.(a) FULL NAME: Estelle Chase

3.(b) Social Security Number: ———

4. Sex: Female
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Arthur Chase
6.(c) If alive, give age: 68 years
7. Birth date of deceased (mo., day, yr.): August 18, 1897
8. AGE: Years: 50 Months: 11 Days: 13 If less than one day: ....hrs. ....min.
9. Birthplace: Annapolis, Maryland
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: None
FATHER
12. Name: Jacob Carpenter
13. Birthplace: Anne Arundel, Co. Md.
MOTHER
14. Maiden name: Rebecca Hampton
15. Birthplace: Anne Arundel, Co. Md.
16. Informant: Blanche Carpenter
Address: 72 Franklin Street
17. Burial (Burial, cremation, or removal. Which?) Date thereof August 4, 1948 (month) (day) (year)
Cemetery or crematory: Brewer Hill Cemetery
Location: West Street Extended
18. Funeral director: Mrs. Charles E. Hicks
Address: 43-45 Northwest Street
19. August 4 19 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 19 48 at 12 40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 19 47 to July 31 19 48 and that I last saw h— alive on July 17 19 48

Immediate cause of death	DURATION
Carcinoma of breast with metastasis of vital organs	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ....Date of op. ....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. T. Allen M.D.
Address: 10 Carroll M. D. or other
Date signed: 8-2-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

1

VS A15 9-45.15

RECEIVED
AUG 6 1948
BUREAU V. S.

Evidence for correction of age shown on:

FILM No. G 117 SEP 16 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

930a

06866

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 64 Yrs.

Hospital, institution, or street address where death occurred: 38 Cornhill Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel Co.

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 38 Corn hill Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Issiah Chase

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Alice Chase

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): October 1, 1883

8. AGE: Years	Months	Days	If less than one day
65 64	9	18	hrs. min.

9. Birthplace: Waterbury, A.A.Co. Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: None

FATHER

12. Name: Daniel Chase

13. Birthplace: Anne Arundel Co. Md.

MOTHER

14. Maiden name: Frances Waters

15. Birthplace: Anne Arundel Co. Md.

16. Informant: Alice Chase

Address: 38 Cornhill Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7- 22- 1948 (month) (day) (year)

Cemetery or crematory: Brewer Hill Cemetery

Location: West Street Extended

18. Funeral director: Mrs. Charles E. Hicks

Address: 43-45 Northwets Street

19. July 21 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19, 1948, at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6, 1948, to July 19, 1948 and that I last saw h[illegible] alive on July 19, 1948

Immediate cause of death	DURATION
Acute Myocarditis	
Due to: Arterio-Sclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: 110 - 8th St. Annapolis Date signed 7/21/48

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

RECEIVED
JUL 22 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

124 L 06863

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Galesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(If nonresident or unborn infant, give residence of mother)
State: Maryland County: Anne Arundel
City or town: Galesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Henry Cherry

3.(b) Social Security Number 217-03-5797

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Unknown

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1890 ?

8. AGE: Years 58 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Unknown (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Unknown
FATHER 13. Birthplace Unknown
MOTHER 14. Maiden name Unknown
MOTHER 15. Birthplace Unknown

16. Informant William Woodfield
Address Galesville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 22-48 (month) (day) (year)
Cemetery or crematory Quaker Cemetery
Location Galesville Md

18. Funeral director D. A. Standiford & Son
Address Galesville Md.

19. 7/22 48 (Date rec'd by registrar) W. M. Clayton Dep Reg Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 19 48, at 10 30 P M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ 19 ..... to 19 ..... and that I last saw ~~him~~ alive on 19 .....

Post mortem Examination

Immediate cause of death	DURATION
Acute Dilatation of Heart	
Due to Cirrhosis of liver	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE John M. Caffey M.D. Deputy Medical Examiner
M. D. Coroner
Address Annapolis, Md Date signed 7-19-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUL 2? 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

49a C6868

CERTIFICATE OF DEATH

Reg. Diat. No. 20

1. PLACE OF DEATH:

County Anne Arundel County

City or town West River - Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia.

City or town Washington - D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. The West Chester Apartment.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Elizabeth Lutz Clagett -

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed.

6.(b) Name of husband or wife Chas. T. Clagett.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 17, 1879

8. AGE: Years	Months	Days	If less than one day
69	2	14	..... hrs. ..... min.

9. Birthplace Leesburg - Loudoun Co. Va.
(Town, county, and state)

10. Usual occupation None -

11. Industry or business

FATHER
12. Name Samuel Lutz.
13. Birthplace Washington D.C.

MOTHER
14. Maiden name Ida Fackler.
15. Birthplace Washington - D.C.

16. Informant Susan C. Hacker.

Address West River - Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-3-48 (month) (day) (year)

Cemetery or crematory Union Cemetery.

Location Leesburg, Va.

18. Funeral director J.S. Gawler Sons Wash. D.C.

Address 1756 Pennsylvania Ave.

19. 7/8 (Date rec'd by registrar) 19 48 M Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 19 48, at 10:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 19 47, to July 1 19 48 and that I last saw h alive on July 1 19 48

Immediate cause of death	DURATION
Carcinoma of ovary	
Due to diffuse metastases	
Due to	
Other conditions	

(Includo pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Emily H Wilcox, M.D. M. D. or other

Address Lothian - Md. Date signed 7/2/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1948-6-31
69-2-14
1879-4-17

RECEIVED
JUL 6 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186a

06869

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? dead on arrival
Hospital, Institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution? dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant give residence of mother)
State Maryland County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4613 Norwood Drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Kate Cooke

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 15 1863 ?

8. AGE: Years about 85. | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace King George County, Virginia
(Town, county, and state)

10. Usual occupation — — —

11. Industry or business — — —

FATHER 12. Name unknown
13. Birthplace

MOTHER 14. Maiden name unknown
15. Birthplace

16. Informant Mrs. Alice Mann
Address 4613 Norwood St., Chevy Chase Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof July 4, 1948 (month) (day) (year)
Cemetery or crematory Round Hill Cemetery,
Location Shiloh, Va.

18. Funeral director Chevy Chase Funeral Home
Address 5101 Wisconsin Ave. N.W.

19. July 4 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

35

20. DATE OF DEATH July 4 1948 at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~
Post mortem Examination
~~and that I last saw him alive on~~ July 4 1948

Immediate cause of death	DURATION
Fracture of neck	
Due to Fall down stairway	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident Date of 7-4-48
Where did injury occur? Edgewater A.A., Maryland
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Mr. H. S. Lyon's home
Means of injury Fall down stairway Injured at work? no

23. SIGNATURE John M. Clafly M.D. Deputy Medical Examiner
M.D. or Other
Address Annapolis, Md. Date signed 7-4-48

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner's certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 7 1948
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

66 f 06870

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 Years
Hospital, institution, or street address where death occurred: 38 College Creek Terrace
How long in hospital or institution? ———

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 38 College Creek Terrace
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Fredrick Davis Jr.

3.(b) Social Security Number: 213-14-9070

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Divorced

6.(b) Name of husband or wife: ———
6.(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.): July 14, 1893

8. AGE: Years	Months	Days	If less than one day
55	0	7	...hrs. ...min.

9. Birthplace: Davidsonville A.A.Co. Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: None

FATHER
12. Name: Ned Davis
13. Birthplace: Davidsonville A.A.Co. Md.

MOTHER
14. Maiden name: Margret Carroll
15. Birthplace: Davidsonville A.A.Co. Md.

16. Informant: Fredrick Davis Jr.
Address: 202 Vernon Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7- 25- 1948 (month) (day) (year)
Cemetery or crematory: Davidsonville Cemetery
Location: Davidsonville Md.

18. Funeral director: Mrs. Charles E. Hicks
Address: 43-45 Northwest Street

19. July 23 19 48 (Date rec'd by registrar) Wm. Branch Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21 19 48 at 10 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-4 19 48 to 7-21 19 48 and that I last saw him alive on 7-21-48 19...

Immediate cause of death	DURATION
~~Senile Psychoses~~ Acidosis	
Due to Senile Psychoses	
Due to	
Other conditions Malnutrition and dehydration	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: C. T. Allers M. D. or other
Address: 10 Carroll Date signed 7-21-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

RECEIVED
JUL 24 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

06873

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County A. A. Co. Glen Burnie

City or town Quarterfield Rd

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A. Co.

City or town Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

Street No. Quarterfield Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Joshua H. Donaldson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mamie L. Warfield

6.(c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) April 15, 1869

8. AGE: Years 79 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Joshua Donaldson

13. Birthplace Maryland

MOTHER 14. Maiden name Mary Jane Charles

15. Birthplace Maryland

16. Informant Mrs Mamie Donaldson

Address Quarterfield Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/29/48 (month) (day) (year)

Cemetery or crematory Friendship

Location Anne Arundel Co. Md.

18. Funeral director John F Denny Inc

Address 715 Light St.

19. 7/29 19 48 D.W. Hedrick D.R. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27th 1948 at 3 13 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 38, to Thurs July 27th 1948

and that I last saw h.i.m. alive on Thurs July 20th 1948

Immediate cause of death	DURATION
a Hypertension - Cerebral involvement	2 yrs
Loss of Memory - and speech -	
Due to Followed by inability to	
Swallow and Lung Involvement	3 or 4 days
Due to Coma	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ✓

Date of op.

Autopsy results ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frederick V. Dentler M. D. or other

Address 723 Medical Arts Bldg - Balto. Date signed 7-28-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

06872

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH

County A. A. Co.

City or town opp. Cedarhurst (Chesapeake Bay) (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Body found at Naval Air Station

How long in hospital or institution? near Annapolis Md

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State County

City or town Washington D. C. (If outside city or town limits, write RURAL and give nearest town)

Street No. 733 6th Street N.W. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Lawrence L. East

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widower

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29 1883

8. AGE: Years 64 | Months 10 | Days | If less than one day hrs. min.

9. Birthplace Va. (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER 12. Name John East

13. Birthplace Va.

MOTHER 14. Maiden name Sarah Norris

15. Birthplace Va.

16. Informant Lawrence Wm. East

Address 803 Mass. Ave. N.E. Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-14-48 (month) (day) (year)

Cemetery or crematory Fort Lincoln Cemetery

Location Prince George's County Md.

18. Funeral director B. J. Leffell

Address 475 H St. N.W. Wash. D.C.

19. July 13 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July (month) 48 (day) at M

21. I CERTIFY that death occurred on the date above stated: (a) Autopsy Examination 19 48 and that I last saw deceased alive on July 12 19 48

Immediate cause of death	DURATION
Drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accidental? Date of (month) (day) (year)

Where did injury occur? opp. Cedarhurst (City or town) A.A (County) Md (State)

Injured at home, farm, industry, public place (where?) Chesapeake Bay

Means of injury Drowning Injured at work? ?

23. SIGNATURE John M. Lafty M.D Deputy Medical Examiner (M. D. of other)

Address Annapolis Md Date signed 7/12/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
JUL 14 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932 06871

CERTIFICATE OF DEATH

Reg. Diat. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. (The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15

1. PLACE OF DEATH: A. A.
County .....
City or town Waterbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A.
City or town Waterbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. .....
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME William Edwards — **3. (b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	widow

6.(b) Name of husband or wife Cora Edwards
Deceased 6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) (unknown) 1871

8. AGE: Years	Months	Days	If less than one day
77			..... hrs. ..... min.

9. Birthplace A. A. Co. (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Edward Edwards
13. Birthplace A. A.
MOTHER 14. Maiden name unknown
15. Birthplace "
16. Informant Harry Edwards
Address Crownsville, R.D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 4 1948 (month) (day) (year)
Cemetery or crematory John Wesley
Location Waterbury
18. Funeral director Annie G. Johnson
Address Annapolis
19. July 3, 1948 (Date rec'd by registrar) E. F. Joyce Local Registrar

MEDICAL CERTIFICATION P.C.

20. DATE OF DEATH July 4 1948, at 4:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1, 1948, to July 4, 1948, and that I last saw him alive on July 4, 1948.
Immediate cause of death Chronic Myocarditis — DURATION 6 months
Due to Arterio-Sclerosis — 1 year
Due to .....
Other conditions None
(Include pregnancy within 3 months of death)
Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE R. L. Richardson, M.D. M. D. or other
Address 110 - Clay St. Annapolis Date signed 7/2/48

RECEIVED
JUL 9 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06874

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 yrs

Hospital, institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 165 Main St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: BERNARD WILLIAM ENGELKE

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Vera M. Engelke

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): November 12, 1894

8. AGE: Years	Months	Days	If less than one day
53	8	11	...hrs. ...min.

9. Birthplace: Eastport, A.A. Co. Maryland
(Town, county, and state)

10. Usual occupation: Welding

11. Industry or business:

FATHER — 12. Name: George Engelke

13. Birthplace: Annapolis, Maryland

MOTHER — 14. Maiden name: Else Harrison

15. Birthplace: Maryland

16. Informant: Mrs. Bernard Engelke

Address: 165 Main Street, Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 26, 1948 (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetery

Location: Annapolis, Maryland

18. Funeral director: Ben L. Hopping and Son

Address: 170-172 West St. Annapolis, Md.

19. July 26 19 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 23 19 48, at 6A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14 19 48 to July 22 19 48 and that I last saw h... alive on July 22 19 48

Immediate cause of death	DURATION
Chronic myocarditis	9 mos.
Due to: Aneurysm of Aorta	unknown
Due to: Gumma of left lung	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findiors of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John M. Caffey M.D.
M. D. or other

Address: Annapolis Md. Date signed 7-24-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

RECEIVED
JUL 27 1948
BUREAU V. S.

06875

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 23 Francis Street
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Ella May Ferguson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife John W. Ferguson
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) May 25th 1873

8. AGE: Years	Months	Days	If less than one day
75	1	18	hrs. min.

9. Birthplace Annapolis, Maryland (Town, county, and state)
10. Usual occupation Invalid
11. Industry or business

FATHER
12. Name Frank Welch
13. Birthplace Pa.

MOTHER
14. Maiden name Mary Logan
15. Birthplace Annapolis, Md.

16. Informant Frederick T. Merriken
Address 23 Francis St. City

17. Burial Date thereof 7-14-48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Cedar Bluff
Location Annapolis, Md.

18. Funeral director John H. Taylor Son
Address Annapolis, Md.

19. July 14 1948 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12, 1948 at 11 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1946 to July 12, 1948 and that I last saw h[illegible] alive on July 12, 1948

Immediate cause of death	DURATION
Broncho-pneumonia	2 wks.
Due to Cerebral Hemorrhage with Hemiplegia	1 yr.
Due to Hypertensive Cardio-Vascular Disease	10 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James R. Martin, M.D.
M. D. or other
Address Annapolis, Md. Date signed 7-13-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

RECEIVED
JUL 15 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

06876

Reg. Dist. No. 20

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Gabsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Gabsville Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Charles Foot

3.(b) Social Security Number: 217-07-3389

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	married

6.(b) Name of husband or wife: Mary Foot

9.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1881

8. AGE: Years: 67 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace (Town, county, and state): Shadyside, A.A. Co. Md

10. Usual occupation: Farming

11. Industry or business:

FATHER — 12. Name: Charles Foot

13. Birthplace: Md

MOTHER — 14. Maiden name: Harriet Foot

15. Birthplace: Md.

16. Informant: Mary Foot

Address: Gabsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 24 1948 (month) (day) (year)

Cemetery or crematory: Daniel Stay Run

Location: West River Md

19. Funeral director: T. A. Hardesty & Son

Address: Gabsville, Md.

19. July 23 48 (Date rec'd by registrar) M. A. Taylor Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 20 1948, at 6 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 13 1948 to July 20 1948

and that I last saw him alive on July 20 1948

Immediate cause of death: Apoplexy

	DURATION
Due to: Hypertension Cardiac Vascular Disease	7 days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Theodore R. Johnson M.D. M. D. or other

Address: 40 Northwest Church Date signed: 7/24/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

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8741

RECEIVED
JUL 24 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

159

Reg. Dist. No. 06877

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Fort George G. Meade, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 hours 24 min

Hospital, institution, or street address where death occurred:
Station Hospital Fort Geo G. Meade, Md.

How long in hospital or institution? 18 Hours 24 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Fort George G. Meade, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: WILLIAM EDWARD GAGNE

3.(b) Social Security Number: * *

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	- -

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 24 July 1948

8. AGE: Years	Months	Days	If less than one day
			18 hrs. 24 min.

9. Birthplace: Fort George G. Meade, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: James Victor Gagne, Jr.
13. Birthplace: Cheyenne, Wyo

MOTHER
14. Maiden name: Mary Ruth Earline Still
15. Birthplace: Spartenburg, S.C.

16. Informant: James Gagne
Address: Fort Geo G. Meade, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 26 July 1948 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Arlington National Cemetery, Virginia.

18. Funeral director: J. Arthur Walters

Address: Laurel, Maryland.

19. 30 July 19 48 (Date rec'd by registrar) James N. Goerger, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 25 July 19 48 at 1040A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 24 July 19 48 to 25 July 19 48

and that I last saw h im alive on 25 July 19 48

Immediate cause of death	DURATION
prematurity	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Norman N. Wrubel
NORMAN N. WRUBEL 1ST LT M. D. or other MC

Address: MSC Sta Hosp Ft Meade, Md. Date signed: 25 July 48

RECEIVED
AUG 3 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06878

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:

County: a a.

City or town: Brooklyn — Balto. 25

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yr.

Hospital, Institution, or street address where death occurred: # 4 W. 11th Ave

How long in hospital or institution? Brooklyn Park

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: a a

City or town: Brooklyn Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.: # 4 W. 11th Ave #25

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Charles Murray Gill

3. (b) Social Security Number: 214-0-1-7072

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Rosetta A. Gill

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Nov. 3 - 1885

8. AGE:

Years	Months	Days	If less than one day
63	4	9	..... hrs. ..... min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual occupation: Coffee grinder

11. Industry or business:

FATHER — 12. Name: Samuel Murray Gill

FATHER — 13. Birthplace: Baltimore —

MOTHER — 14. Maiden name: Margaret Wagner

MOTHER — 15. Birthplace: Germany —

16. Informant: Mrs. Rosetta Gill - (wife)

Address: 4 W 11th Ave - Brooklyn Park

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/15/48 (month) (day) (year)

Cemetery or crematory: Woodlawn

Location: Balto County, Md.

18. Funeral director: Wm J. Packer & Sons

Address: Balto. Md.

19. 7-13-48 (Date rec'd by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 12 19 48, at 9:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 25 19 48, to July 12 19 48, and that I last saw him alive on July 12 - 19 48

Immediate cause of death	DURATION
Cerebral Haemorrhage	4½ hrs.
Due to: Uremic-sclerosis	5 yr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Chas. L. Ball Jr. MD

M. D. or other

Address: Kirkwood Date signed 7-12-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

06879

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County Anne Arundel
City or town Pasadena P.O. Bodkins' Creek
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? a few hours
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Fullerton, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8512 Willow Oak Road
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Goma C. Gooch

3. (b) Social Security Number 455-07-9032

4. Sex male
5. Color or race White
6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Theona V. Gooch
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Aug. 27th, 1913
8. AGE: Years 34 Months 10 Days 8 If less than one day ... hrs. ... min.
9. Birthplace Dallas, Texas (Town, county, and state)
10. Usual occupation Radio Engineer
11. Industry or business W B M D
FATHER 12. Name Francis C. Gooch
13. Birthplace Tennessee
MOTHER 14. Maiden name Debbie Ramsey
15. Birthplace Tennessee
16. Informant Mrs. G.C. Gooch
Address 8530 Willow Oak Ave.
17. burial (Burial, cremation, or removal. Which?) Date thereof July 8th 1948 (month) (day) (year)
Cemetery or crematory Parkwood
Location Baltimore, Md.
18. Funeral director Lassahn Funeral Home
Address 7401 Belair Rd.
19. July 7 1948 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1948, at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Postmortem Examination ~~and that I last saw h... alive on~~ July 5 1948

	DURATION
Immediate cause of death	
Due to Drowning	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 7-5-48
Where did injury occur? Pasadena P.O. (City or town) A.A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?) Bodkins Creek
Means of injury Drowning Injured at work? No

23. SIGNATURE John M. Claffy M.D. Deputy Medical Examiner M.D. or other
Address Annapolis, Md. Date signed 7-5-48.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

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06880 24

Reg. Diat. No.

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, Institution, or street address where death occurred: Crownsville State Hospital, Crownsville, Md.

How long in hospital or Institution? 1 year

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: -------

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 869 W. Lexington Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ---------- ✓

3. (a) FULL NAME: HATTIE GREEN

3. (b) Social Security Number: -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	negro	married

6.(b) Name of husband or wife: Douglas Green

6.(c) If alive, give age: ---

7. Birth date of deceased (mo., day, yr.): 1908

8. AGE: Years	Months	Days	If less than one day
40	---	---	---hrs. ---min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: ----- ----

FATHER
12. Name: Will Belle
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Mamie Thomsen
15. Birthplace: North Carolina

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Shipped (Burial, cremation, or removal. Which?) Date thereof July 10, 1948 (month) (day) (year)
Cemetery or crematory: Selma North Carolina
Location:

18. Funeral director: Katie R. Williams
Address: 322 North Schroder St, Baltimore, Md.

19. 7/10 (Date rec'd by registrar) 19 48 A W Kelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7 19 48 at 1:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 19 47 to July 7 19 48 and that I last saw her alive on July 7 19 48

Immediate cause of death	DURATION
General Paresis	
known to us since	7/19/47
Due to	
Due to	
Other conditions: General Paresis	
known to us since	7/19/47

(Include pregnancy within 3 months of death)

Major findings of operations: ----------

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------- Date of -----

Where did injury occur? ---------- (City or town) (County) (State) -------

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jacob Augenstein M.D.
M. D. or other

Address: Crownsville, Maryland Date signed 7/7/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95C

06881

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County: A. A. County
City or town: Lakeshore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs.
Hospital, Institution, or street address where death occurred:
None
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A. County
City or town: Lakeshore
(If outside city or town limits, write RURAL and give nearest town)
Street No. .....
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: John Gumpman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Minnie Rome
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 11/15/1885

8. AGE: Years	Months	Days	If less than one day
62	8	14	..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: Fisherman
11. Industry or business

FATHER
12. Name: John Gumpman
13. Birthplace: Md.

MOTHER
14. Maiden name: Kunidunda Wieman
15. Birthplace: Md.

16. Informant: Minnie Gumpman
Address: R.F.D. 1 Lakeshore, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof 8/2/48 (month) (day) (year)
Cemetery or crematory: Holy Cross
Location: Ritchie Highway

18. Funeral director: Lilly & Zeiler Inc.
Address: 403 S. Wolfe St. 31

19. aug 2 1948 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 29, 1948, at 7:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 18, 1948, to Mar. 6, 1948, and that I last saw him alive on Mar. 6, 1948.

Immediate cause of death	DURATION
Acute Heart Failure	
Due to: Coronary occlusion with myocardial infarction	
Due to: Coronary sclerosis	
Other conditions: Hypertension; cardiac hypertrophy	

(Include pregnancy within 3 months of death)

Major findings of operations: None — Date of op. —

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: A. F. Gadaus M.D.
M. D. or other
Address: Pasadena, Md. Date signed: July 29 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFAILING INK. Supply every item of information carefully. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932 06882

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County A A. Co.
City or town West State RFD 1 Box 33
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 42 years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County A A.
City or town West State RD 1 1 Box 33
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Elizabeth Harris

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	Widow

6.(b) Name of husband or wife John Harris
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) March 1 1871

8. AGE: Years 77 | Months 4 | Days 19 | If less than one day ... hrs. ... min.

9. Birthplace A A Co. Md. (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER
12. Name Charles Simon
13. Birthplace A A. Co. Md.

MOTHER
14. Maiden name Allen
15. Birthplace A A. Co Md.

16. Informant James Weems
Address West State RFD 1 Box 33

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 23 1948 (month) (day) (year)
Cemetery or crematory Fowlers Chapel
Location West State

18. Funeral director T A Hardesty & Son
Address Galesville Md

19. July 22 19 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 19 48 at 2 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13, 19 48 to July 20 19 48
and that I last saw ... alive on July 20 19 48

	DURATION
Immediate cause of death Arteriosclerotic-Cardiovascular disease	1 yr.
Due to Carbus Delalalan	5 Days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE Albert L. Anderson M.D. M. D. or other
Address Annapolis, Md Date signed July 21 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

RECEIVED
JUL 23 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06883

131a

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Skidmore, near Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Skidmore, near Annapolis

How long in hospital or institution? ----------

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Skidmore, near Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. Skidmore, near Annapolis

(If rural, give LOCATION)

2.(a) If veteran, name war: World War 1

3. (a) FULL NAME

Vachel Asbury Harris

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Amelia Harris

6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): March 26, 1892

8. AGE: Years	Months	Days	If less than one day
56	3	22	....hrs. ....min.

9. Birthplace: Skidmore, near Annapolis (Town, county, and state)

10. Usual occupation: Building Attendent

11. Industry or business: None

FATHER 12. Name: Vachel Harris

13. Birthplace: Skidmore, near Annapolis

MOTHER 14. Maiden name: Louisa Colbert

15. Birthplace: Skidmore, near Annapolis

16. Informant: Amelia Harris

Address: Skidmore, near Annapolis

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7- 22- 1948 (month) (day) (year)

Cemetery or crematory: Broad Neck

Location: Skidmore, near Annapolis

18. Funeral director: Mrs. Charles E. Hicks

Address: 43-45 Northwest Street

19. July 21 19 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-1-48 at 6.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-18-48 to 7-1-48 and that I last saw him alive on 7-1-48

Immediate cause of death	DURATION
(1) Hypertensive Cardio-vascular Disease	
(2) Arteriolo Nephrosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: G. T. Talbert M. D. or other

Address: 10 Carroll Date signed 7-20-48

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 22 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

30 f 06884

Reg. Dist. No. 28

M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? since Dec. 1944
Hospital, institution, or street address where death occurred: State Hospital
How long in hospital or institution? Dec. 18th, 1944

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George
City or town: 718 Fairmount Hts
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME: HAWKINS, WARREN
3.(b) Social Security Number

4. Sex: M
5. Color or race: C.
6.(a) Single, married, widowed, or divorced:
6.(b) Name of husband or wife: Julia Hawkins
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): March 1st, 1908
8. AGE: Years: 40 Months: 4 Days: 15 If less than one day: hrs. min.
9. Birthplace: Pa. (Town, county, and state)
10. Usual occupation: laborer
11. Industry or business:
FATHER 12. Name: ?
13. Birthplace:
MOTHER 14. Maiden name: ?
15. Birthplace:
16. Informant: Julia Hawkins
Address: 718 Fairmount Hts Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-19-48 (month) (day) (year)
Cemetery or crematory: Payne Cemetery
Location: 4600 Benning Rd. N.E., D.C.
18. Funeral director: Myrtle K. Rollins
Address: 4933 Hunt Pl. N.E. 264
19. July 16 19 48 (Date rec'd by registrar) E.F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15th 19 48 at 6 p.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 18 19 44 to 7-15 19 48 and that I last saw h... alive on 7-15-48 19 ...

	DURATION
Immediate cause of death: exhaustion and cachexia	
Due to: cachexia general paresis	
Due to: paresis's	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: Jacob Marquette M.D. M. D., or other
Address: ... Date signed: ...

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 22 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

06885

2C

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Franklin Manor Beach

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D C County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 162 Upland Ter NE

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Mary Jane Hill

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 31, 185[illegible]

8. AGE:

Years	Months	Days	If less than one day
93	6	0	hrs. min.

9. Birthplace: Washington, D.C.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER

12. Name: Georg Fastnaught

13. Birthplace: Germany

MOTHER

14. Maiden name: Mary Ellen Burgess

15. Birthplace: Washington, D C

16. Informant: Lelia M Fay

Address: 162 Upland Ter NE DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 2 1948 (month) (day) (year)

Cemetery or crematory: Glenwood

Location: Lincoln Rd NE

18. Funeral director: W W Chaney Co

Address: Riverdale Md.

19. 7/31 1948 (Date rec'd by registrar) W. R. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 1948, at 6:30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 July 1948 to 31 July 1948 and that I last saw h[illegible] alive on 30 July 1948

	DURATION
Immediate cause of death: Acute Coronary Insufficiency	24 hrs
Due to: Arteriosclerotic Cardio-Vascular Disease	Unk
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert B Lasseter M. D.

Address: Upper Marlboro, Md Date signed: 31 July 48

RECEIVED
AUG 2 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore

94a

06886

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:

County Anne Arundel.

City or town West Shekyside

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, Institution, or street address where death occurred:

Same

How long in hospital or Institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Same County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Elmer L. Dey

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife Marguerite W. Dey 6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) 60 March 10, 1888

8. AGE: Years 60 | Months 4 | Days 9 | If less than one day ... hrs. ... min.

9. Birthplace Kansas City, Mo. (Town, county, and state)

10. Usual occupation Tax consultant.

11. Industry or business

FATHER 12. Name Charles Dey.

13. Birthplace Missouri

MOTHER 14. Maiden name Elizabeth Sandys.

15. Birthplace Baltimore, Md.

16. Informant Son - Highwood

Address 1833 - Monroe St N.W.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July - 22 - 1948 (month) (day) (year)

Cemetery or crematory Fort Lincoln Cem

Location Wash. D.C.

18. Funeral director The D. J. Kiss Co.

Address 2901-14th St N.W. Wash D.C.

19. July 19, 1948 (Date rec'd by registrar) J. B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1948, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 years 1948 to 1948

and that I last saw h[illegible] alive on July 19 1948

Immediate cause of death	DURATION
Coronary Thrombosis	one day
Due to	
Due to	
Other conditions Heart Failure	1 years

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. H. Keith md M. D. or other

Address 1833 - Monroe Wash D.C. Date signed 7/19/48

PLEASE WRITE PLAINLY, WITH INDELIBLE PENCIL OR FADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

RECEIVED
JUL 23 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

84b

06887

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs. 9 mos.

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 6 yrs. 9 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Tuxedo

(If outside city or town limits, write RURAL and give nearest town)

Street No. ---

(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3. (a) FULL NAME

LUCILLE JAMES

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	negro	single

6.(b) Name of husband or wife: ----

6.(c) If alive, give age: --

7. Birth date of deceased (mo., day, yr.): unknown

8. AGE:

Years	Months	Days	If less than one day
33			...hrs. ...min.

9. Birthplace: Alabama (Town, county, and state)

10. Usual occupation: domestic

11. Industry or business: ----

FATHER

12. Name: Eli James

13. Birthplace: Alabama

MOTHER

14. Maiden name: Rilla Cotton

15. Birthplace: Alabama

16. Informant: Hospital Records

Address: Crownsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-30-48 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville

18. Funeral director: Asylum Hospital

Address: Crownsville

19. July 30 1948 (Date rec'd by registrar) E. T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21 19 48 at 1:00a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 30 19 41 to July 21 19 48

and that I last saw her alive on July 21 19 48

	DURATION
Immediate cause of death	
Due to	
Due to	
Other conditions: Schizophrenia, Paranoid Type known to us since 10/30/41	

(Include pregnancy within 3 months of death)

Major findings of operation: ----

---- Date of op.

Autopsy results: Pneumonia Hypostatica Pulmonis Dextri

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ----

Means of injury: ---- Injured at work?

23. SIGNATURE: Jacob Morgenstern M.D. M. D. or other

Address: Crownsville, Md. Date signed 7/21/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
AUG 2 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

#46b

06888

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Pasadena
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Vise Ave. Green Haven
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Anne Arundel
City or town: Pasadena
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Vise Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME JOHN J. JARZYNSKI

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	married

6.(b) Name of husband or wife: Mary
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 20 d 1885

8. AGE:

Years	Months	Days	If less than one day
63	1	20	..... hrs. ..... min.

9. Birthplace: Poland (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: Henry Jarzynske
13. Birthplace: Poland

MOTHER
14. Maiden name: Mary Grackowske
15. Birthplace: Poland

16. Informant: Mrs. Mary Jarzynski
Address: Vise Ave. Pasadena Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 26-48 (month) (day) (year)
Cemetery or crematory: Sacred Heart
Location: Germany Hill Rd
18. Funeral director: John G. Connelly
Address: 418 Eastern Ave.
19. 7/24/48 (Date rec'd by registrar) B.W. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21 1948 at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 27 1947 to July 21 1948 and that I last saw him alive on July 21 1948

Immediate cause of death	DURATION
Carcinoma of Stomach	2 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: J. Brady Smith M.D.
M. D. or other
Address: Riviera Beach Md. Date signed 7/24/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 06889

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Mayo
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State: Md. County: A. A.
City or town: Mayo
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Benjimen Joyce

3.(b) Social Security Number: 230-09-5982

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Col	Divorced

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1895

8. AGE: Years: 53 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Mayo (Town, county, and state)
10. Usual occupation: Systeman
11. Industry or business
FATHER 12. Name: Unknown
13. Birthplace: "
MOTHER 14. Maiden name: Joyce
15. Birthplace: Mayo
16. Informant: Solomon Nichols
Address: Mayo
17. Burial (Burial, cremation, or removal? Which?) Date thereof July 25-48 (month) (day) (year)
Cemetery or crematory: Mayo Cemetery
Location: Mayo Md.
18. Funeral director: C. A. Hardesty & Son
Address: Gallsville Md.
19. July 24 1948 (Date rec'd by registrar) Edward Calleman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22 1948, at 12:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1948 to July 22, 1948 and that I last saw him alive on July 28, 1948
Immediate cause of death: Pulmonary Tuberculosis — DURATION: 1 Year
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings at operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Dr. R. S. Richardson, M. D. or other
Address: 110 - Clay St. Annapolis Md. Date signed: 7/23/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

RECEIVED
JUL 27 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

06890

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County A. A. Co.

City or town Brooklyn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Anne Arundel

City or town Brooklyn

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4601 Ritchie Highway

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Julia T. Klemkowski

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Walter

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 75 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Poland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Peter Tylecka

FATHER 13. Birthplace Poland

MOTHER 14. Maiden name

MOTHER 15. Birthplace Poland

16. Informant Dr. Irvin Klemkowski

Address 3833 Clifton Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 12-1948 (month) (day) (year)

Cemetery or crematory Holy Rosary

Location Balto. Co. Md

18. Funeral director Wm. S. Fialkowski

Address 2007 Eastern Ave

19. July 9 1948 A. W. Hedrick

(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1948, at 4:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24 1946, to July 18 1948 and that I last saw h.e.r alive on July 6, 1948

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE P. J. Ignaldi M. D.

M. D. or other

Address 4609 Gd. Ritchie Hwy Date signed July 9, 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45.15

1948
75
1873

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

pe 97

06891

Reg. Dist. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 mos.
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 9 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ---
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1105 N. Gilmor St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ----

3. (a) FULL NAME: CHARLES MACLEOD

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	negro	married

6.(b) Name of husband or wife: Daisy Macleod
6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1888

8. AGE: Years: 60 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Chesterfield, South Carolina
(Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: ---

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/30/48 (month) (day) (year)
Cemetery or crematory: Mt Auburn
Location: Md.

18. Funeral director: Geo. G. Kelson
Address: 1303 Orestman St

19. 7/29 19 48 Aw. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 19 48, at 1:15 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 17 19 47, to July 27 19 48
and that I last saw him alive on July 27 19 48

Immediate cause of death: General Arteriosclerosis — DURATION: 10/17/47
known to us since

Due to:

Due to:

Other conditions: Psychosis with Cerebral Arteriosclerosis
known to us since 10/17/47
(Include pregnancy within 3 months of death)

Major findings of operations: ----
Date of op.: ----

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---- Date of
Where did injury occur? ---- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ----
Means of injury: --- Injured at work?

23. SIGNATURE: Jacob Mayerson M.D.
M. D. or other
Address: Crownsville, Md. Date signed 7/27/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131b 06892

Reg. Dist. No. 22

1. PLACE OF DEATH:
County A.A.
City or town Jessups, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 47 days
Hospital, institution, or street address where death occurred:
Hospital, Md. House Correction.
How long in hospital or institution? In Hospital 9 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Annie Arundel
City or town Jessups
(If outside city or town limits, write RURAL and give nearest town)
Street No. Md. House of Correction
(If rural, give LOCATION)
(FORMER RESIDENCE UNKNOWN)
2.(a) If veteran, name war

3.(a) FULL NAME GEORGE MARTIN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

B.(b) Name of husband or wife None

6.(c) If alive, give age - - years

7. Birth date of deceased (mo., day, yr.) March 14, 1888.

8. AGE:

Years	Months	Days	If less than one day
60	4	2	- hrs. - - min.

9. Birthplace New York. (Town, county, and state)

10. Usual occupation - - -

11. Industry or business - - -

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden name "
15. Birthplace "

16. Informant Md. House Correction,
Address Jessups, Maryland.

17. Burial, Date thereof Aug 3 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Cherry Hill
Location Jessup Md
18. Funeral director W L Collins
Address Jessup Md

19. Aug 2 1948 Clara Kasluk
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16, 1948, at 9:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7, 1948, to July 16, 1948, and that I last saw him alive on July 16, 1948.

Immediate cause of death	DURATION
Uremia	
Due to Chronic Nephritis	
Due to	
Other conditions Myocardial degeneration.	

(Include pregnancy within 3 months of death)

Major findings of operations - - -
Date of op. - - -
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide - - - - Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John A Clark MD
John A. Clark, M.D. M. D. or other
Address M.H.C. Jessups, Md. Date signed 7-16-48.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
AUG 17 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

85

06893

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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VS-A15

1. PLACE OF DEATH

County: A. A.

City or town: Hanover, Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life-time.

Hospital, institution, or street address where death occurred: Dorsey - Harman's Rd.

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A.A.

City or town: Hanover, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Dorsey - Harman's Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Gladys V. Matthews

3.(b) Social Security Number .....

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 23, 1910

8. AGE: Years: 38 | Months: 6 | Days: 27 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Severn, A. A. Co. Md (Town, county, and state)

10. Usual occupation: H. Home

11. Industry or business .....

FATHER — 12. Name: Samuel G. Matthews

13. Birthplace: Md

MOTHER — 14. Maiden name: Annetta Lomack

15. Birthplace: Md

16. Informant: Samuel G. Matthews

Address: Dorsey - Harmans, Md

17. Burial (Burial, cremation, or removal. When?) Date thereof: 7-22-48 (month) (day) (year)

Cemetery or crematory: St. Rest Cem.

Location: Harmans, Md.

18. Funeral director: Mrs. Frances A. Hemsley

Address: 5786 W. Biddle St.

19. ..... 19..... .....

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 20th 1948, at 3A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 13, 1948, to July 20, 1948, and that I last saw h.. alive on July 19, 1948

Immediate cause of death: Common Cold to Pulmonary Congestion — DURATION: 1 wk.

Due to: .....

Due to: .....

Other conditions: Epilepsy — 15 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank Shipley M.D.

M. D. or other

Address: Savage, Md. Date signed: 7/20/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

93d

06874

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County A. A. County

City or town Magothy River

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3606 Wilkens Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Anna Maurer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

6.(b) Name of husband or wife Rudolph Maurer

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28-1874

8. AGE: Years	Months	Days	If less than one day
74	2	3	— hrs. — min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation House wife

11. Industry or business At Home

FATHER 12. Name William Maurer

FATHER 13. Birthplace Germany

MOTHER 14. Maiden name Unknown

MOTHER 15. Birthplace Germany

16. Informant Julius G. Maurer

Address 3606 Wilkens Ave

17. Burial — (Burial, cremation, or removal. Which?) Date thereof Aug 3-1948 (month) (day) (year)

Cemetery or crematory Loudon Park

Location Baltimore Md.

18. Funeral director E. B. Wippert & Son

Address 1300 Eutaw Pl. 17

19. August 3 19 48 (Date rec'd by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1948, at 2:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 21 1946, to July 28 1948 and that I last saw h.e.r. alive on July 28 1948

Immediate cause of death	DURATION
Arteriosclerotic cardiovascular Disease	?
Due to Hypertension	?
Due to Cardiac Hypertrophy	?
Due to	
Other conditions Obesity	?

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE Carey Rosting M. D. ~~or other~~

Address 1321 W. Lombard St. Date signed 8/2/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

183 06895

CERTIFICATE OF DEATH

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 hrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County: Fairfax
City or town: Falls Church
(If outside city or town limits, write RURAL and give nearest town)
Street No. 611 North Greenleaf
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Chas. McA. Alexander Jr.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 9th 1930

8. AGE: Years 18 | Months 0 | Days 16 | If less than one day: hrs. min.

9. Birthplace: Denver Colo. (Town, county, and state)

10. Usual occupation: Sect. U.S. Navy Dept.

11. Industry or business:

FATHER
12. Name: Charles McA. Alexander Sr.
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs. W. A. Morrell
Address: 3211 Varnum St. Mt. Rainer Md.

17. removal (Burial, cremation, or removal. Which?) Date thereof July 26th 1948 (month) (day) (year)
Cemetery or crematory:
Location: Kansas City Mo

18. Funeral director: John M. Sayler Son
Address: Annapolis Md.

19. July 26 1948 (Date rec'd by registrar) E.T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 25 1948 at 6.55 P.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post Mortem Examination
~~and that I last saw him alive on~~ July 25 1948

Immediate cause of death	DURATION
Drowning	
Due to accidental	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? accident Date of 7-25-48
Where did injury occur? Crownsville (City or town) A.A. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Severn River Naval Academy
Means of injury: Drowning Injured at work? No

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
Address: Annapolis, Md. Date signed 7-28-48

RECEIVED
JUL 29 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06896

93 d

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Millersville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Whitney Landing Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Millersville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Whitney Landing Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: GEORGE CLYDE MITCHELL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widower

6.(b) Name of husband or wife: Katie Mitchell

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 18, 1872

8. AGE: Years	Months	Days	If less than one day
76	3	0	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: "

MOTHER — 14. Maiden name: "

MOTHER — 15. Birthplace: "

16. Informant: Mr. Vincent A. Kaemmer,

Address: Whitney Landing Road, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7/21/48 (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. July 21 19 48 a.m. Registered (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18, 19 48 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10, 19 48 to July 18 19 48 and that I last saw him alive on July 18 19 48

Immediate cause of death	Congestive Heart Failure	DURATION
Due to	Arteriosclerosis Generalized	
Due to	Unknown	
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Henry F. Zangara, M.D. M. D. or other

Address: Glen Burnie Md Date signed: 7/18/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

06897

Reg. Diat. No. 23

1. PLACE OF DEATH:

County A. A.

City or town Glenburnie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr.

Hospital, Institution, or street address where death occurred: # 10 Oak Lane S. W.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A. A.

City or town Glenburnie

(If outside city or town limits, write RURAL and give nearest town)

Street No. 10 Oak Lane - S. W.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sarah Elizabeth Perkins

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	Widowed

6.(b) Name of husband or wife Wm W. Perkins

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 6 - 1848

8. AGE: Years	Months	Days	If less than one day
100	5	10	..... hrs. ..... min.

9. Birthplace Cecil Co. Md. (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Chas. B. Christie

13. Birthplace [redacted] UNKNOWN

MOTHER 14. Maiden name MARY A. ORR

15. Birthplace Md.

16. Informant MRS. CLARA A. McCRACKEN - (DAUGHTER)

Address 10 OAK LANE S.W GLEN BURNIE

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 7/19/48 (month) (day) (year)

Cemetery or crematory BALTO. MEMETERY

Location BALTO, MD.

18. Funeral director Wm. J. TICKNER & SONS

Address BALTO. MD.

19. 7-17 19 48 Rama (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 19 48 at 8:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 40 to July 16 19 48 and that I last saw h[illegible] alive on July 16 19 48

	DURATION
Immediate cause of death Cardio-Vascular D.	4 mos
Due to	
Arterio - sclerosis	10 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of Injury ..... Injured at work?

23. SIGNATURE Chas. L. Bacon Jr. M.D. or other

Address Linthicum Date signed 7-16-'48

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

06898

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: North Severn Naval Station

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: North Severn Naval Station

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rifle Range at Station

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Cooper Peterson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Paul C. Peterson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 25, 1874

8. AGE: Years	Months	Days	If less than one day
74	4	10	..... hrs. ..... min.

9. Birthplace: Montgomery Co. Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Elijah Cooper

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Mary Ann Cooper

15. Birthplace: Unknown

16. Informant: Mary E. Feldmeyer

Address: North Severn Naval Station

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 9th 1948 (month) (day) (year)

Cemetery or crematory: Cedar Bluff Cemetery

Location: Annapolis, Md.

18. Funeral director: John M. Layton & Son

Address: Annapolis, Md.

19. July 8 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6 1948 at 8-15 P. M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post mortem Examination

~~and that I last saw him alive on~~ July 6, 1948

Immediate cause of death	DURATION
Diabetes Mellitus	4 yrs
Due to: Arterio-sclerosis	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: John M. Caffy M.D. M. D. or other — Department Medical Examiner

Address: Annapolis Md. Date signed: 7-6-48

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 9 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06899

932

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
County Anne Arundel
City or town Parole
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Parole
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Richard Phillips

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widower

6.(b) Name of husband or wife: Mary Phillips
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1878

8. AGE: Years	Months	Days	If less than one day
69	7	12	..... hrs. ..... min.

9. Birthplace Anne Arundel Co., Md. (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name Charles Phillips
13. Birthplace Md.
MOTHER 14. Maiden name Mary Gray
15. Birthplace Md.
16. Informant Richard Phillips, Jr.
Address Parole, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof August 5, 1948 (month) (day) (year)
Cemetery or crematory Franklin Cemetery
Location Churchton, Md.
18. Funeral director U J.B. Johnson
Address Annapolis, Md. P.O. Box 462
19. Aug. 5 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1948, at 9:50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw him alive on July 31, 1948
Immediate cause of death Apoplexy — DURATION
Due to Hypertensive Cardio Vascular 2 wks
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations ..... Date of op. .....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE Stanley J. Johnson M.D.
M. D. or other
Address 40 Northwest Blvd Date signed 8/3/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

RECEIVED
AUG 6 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

06900

Reg. Diat. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Deale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A.A.
City or town: Deale
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Ida Phipps

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widow

6.(b) Name of husband or wife: Dean Phipps
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 25. 1862

8. AGE: Years	Months	Days	If less than one day
86	1	29	hrs. min.

9. Birthplace: Schuylkill Pa
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: Joseph Randall
13. Birthplace: Schuylkill Pa

MOTHER
14. Maiden name: Martha Randall
15. Birthplace: Schuylkill Pa.

16. Informant: Marion B. Phipps
Address: Deale

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: July 26 1948
(month) (day) (year)
Cemetery or crematory: Sherbert
Location: Deale
18. Funeral director: T. G. Stardesty
Address: Galesville Md.

19. July 25 1948
(Date rec'd by registrar)
J. B. Dent
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 24 1948 at 7.35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1948, to July 24 1948, and that I last saw h.c.v. alive on 22 July 1948.

Immediate cause of death	DURATION
Generalized Arterio-Sclerosis - severe	Unk
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Robert B. Lasser M. D.
Address: Upper Marlboro Md. Date signed: 25 July 48

RECEIVED
JUL 27 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170C

06901

CERTIFICATE OF DEATH

Reg. Diat. No. 27

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Fort Geo G. Meade, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Fort Geo G. Meade, Md.

How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Penna County: Cambria

City or town: Sidman
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rt #1 Box 69
(If rural, give LOCATION)

2.(a) If veteran, name war: SOLDIER

3. (a) FULL NAME

DONAID ARTHUR PLUMMER

3. (b) Social Security Number

* *

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3-17-1929

8. AGE: Years	Months	Days	If less than one day
19	4	11	hrs. min.

9. Birthplace: Sidman, Penna.
(Town, county, and state)

10. Usual occupation: Soldier

11. Industry or business

FATHER 12. Name: Oliver William Plummer

FATHER 13. Birthplace: Penna.

MOTHER 14. Maiden name: Unknown.

MOTHER 15. Birthplace

16. Informant: Service Record

Address: Fort George G. Meade, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 30 July 48 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Sidman, Penna.

18. Funeral director: Unknown.

Address

19. 30 July 1948 (Date rec'd by registrar)

James N. Georges (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 28 July 1948, at 1000A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
crushing injury of brain	
Due to: crushing of skull	
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 28 July 48

Where did injury occur? Ft G G Meade (City or town) Md AA (County) Md (State)

Injured at home, farm, industry, public place (where?): Army Post

Means of injury: tree trunk Injured at work? Yes

fell on head when armored car struck same.

23. SIGNATURE: Dale T Mellus 1st Lt MC

DALE T. MILLS, 1ST LT., M. D. or other MC

Address: MC Sta Hosp Ft Meade Md Date signed: 29 July 48

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

41-3-429

11-4-41.

82-7-8441

RECEIVED
AUG 3 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06902

Reg. Dist. No. 26

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ---
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 536 N. Bond
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3.(a) FULL NAME: ROLAND PRICE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	negro	married

6.(b) Name of husband or wife: May Price
6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): April 25, 1906

8. AGE: Years	Months	Days	If less than one day
42			...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Worked at Maryland Drydock
11. Industry or business: ---

FATHER
12. Name: William Price
13. Birthplace: Maryland

MOTHER
14. Maiden name: Marceline Haywood
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof July 10, 1948 (month) (day) (year)
Cemetery or crematory: Mt. Calvary Cemetery
Location: Ann Arundel County

18. Funeral director: Charles G. Cooper
Address: 512 N. Carrollton Ave.

19. 7-8-48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6 19 48 at 9:35 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 22 19 48 to July 6 19 48 and that I last saw him alive on July 6 19 48

Immediate cause of death	DURATION
Exhaustion due to	
Sc hizophrenia	
known to us since	6/22/48
Due to	
Due to	
Other conditions: Schizophrenia - Catatonic Type	
known to us since	6/22/48

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work?

23. SIGNATURE: [signature] M. D.
Address: Crownsville, Md. M. D. or other
Date signed: 7/6/48

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06903

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2wks 7 3days
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution? 2 wks & 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Edgewater, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. Edgewater, Maryland
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Harry Randall

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Martha Randall
6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): July 4, 1897

8. AGE: Years	Months	Days	If less than one day
51	0	24	hrs. min.

9. Birthplace: ~~July 4, 1897~~ Harwood, A.A.Co. Md. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: None

FATHER
12. Name: John Randall
13. Birthplace: Anne Arundel Co. Md.

MOTHER
14. Maiden name: Elizabeth Davis
15. Birthplace: Anne Arundel Co. Md.

16. Informant: Martha Randall
Address: Edgewater, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 31, 1948 (month) (day) (year)
Cemetery or crematory: Chews Chapel Cemetery
Location: Owensville, A.A.Co. Md.

18. Funeral director: Mrs. Charles E. Hicks
Address: 43-45 Northwest Street

19. July 30 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 1948 at 5-45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 11 1948 to July 28 1948 and that I last saw him alive on July 28 1948

Immediate cause of death	DURATION
Cerebral hemorrhage	17 days
Due to: arteriosclerosis.	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. J. Kleinans, md M.D. or other
Address: Annapolis Md. Date signed 7/29/48

RECEIVED
AUG 3 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06904

926

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Glen Burnie, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 Years

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)

Street No. 413 Gov. Ritchie Highway
(If rural, give LOCATION)

2.(a) If veteran, name war: World War 1

3.(a) FULL NAME: Cyril Robert (Bob) Reynolds

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret Reynolds
(Nee Kuke 6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): February 3, 1896.

8. AGE:

Years	Months	Days	If less than one day
52	4	29	..... hrs. ..... min.

9. Birthplace: Bird Island, Minn.
(Town, county, and state)

10. Usual occupation: Body & Fender Repair

11. Industry or business: Own Business

FATHER
12. Name: Frederick Reynolds
13. Birthplace: Minnesota

MOTHER
14. Maiden name: Louella Lentz
15. Birthplace: New York

16. Informant: Margaret Reynolds
Address: 413 Gov. Ritchie Highway Glen Burnie, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 5, 1948 (month) (day) (year)

Cemetery or crematory: Glen Haven

Location: Glen Burnie, Md.

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. 7/5 19 48 (Date rec'd by registrar) L. J. Dalton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2nd 1948 at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946 to July 1st 1948 and that I last saw h.... alive on 7/1/48 19....

Immediate cause of death	DURATION
Aortic stenosis and insufficiency	One Yr
Due to Mitral Insufficiency	" "
Due to Cardiac Decompensation	" "
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Gustave W. Faubert M.D.
M. D. or other

Address: Glen Burnie, Md. Date signed 7/3/48

VS A15 9-45.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUL 7 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH — Bureau of Vital Statistics

CERTIFICATE OF ~~STILLBIRTH~~ Death

(159) 06905

Reg. Dist. No. 21

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:
   County A. A. Co.
   City or town Gambrills, md (Rural)
   (If outside city or town limits, write RURAL and give nearest town)
   Street address, hospital, or institution: Home.
   Length of mother's stay in County 6 years.
   (How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:
   State Maryland
   County A. A. Co.
   City or town Gambrills md (Rural)
   (If outside city or town limits, write RURAL and give nearest town)
   Street No. near Davis's Esso Station
   (If RURAL give LOCATION)

3. Name of child
4. Date of birth July 19 1948 Hour 1:30 P.M.
5. Sex Male | 6. Twin or triplet —
7. No. of weeks pregnancy 25 weeks

FATHER OF CHILD

8. Full name James Ridgley
9. Color C 10. Age at time of this birth 43 yrs.
11. Usual occupation Farmer

MOTHER OF CHILD

12. Full maiden name Alice Queen
13. Color C 14. Age at time of this birth 23 yrs.
15. Usual occupation housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 1
    (b) How many other children were born alive but are now dead? 1 (c) How many other children were *born* dead? 2
17. Did child die before labor? No During labor? No
18. Pregnancy, complications of None
19. Labor: (a) Complications of None
    (b) Induced? No
20. (a) Was there an operation for delivery? None (Yes or No)
    (b) State all operations, if any None
    (c) Did child die before operation? —
    During operation?
21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.
    (a) Fetal causes Prematurity Cause unknown
    (b) Maternal causes
22. I certify to the birth of this child who was ~~born dead~~ born died* on the date and hour above stated.
    Signature Edward J. Chenett M.D.
    (Specify if M. D., midwife, or other)
    Address Gambrills Md
23. (a) July 20 1948 (b) Date thereof 7-20-1948
    (Burial, cremation or removal) (month) (day) (year)
    (c) Cemetery or crematory Mt. Tabor
24. (a) Funeral director —
    (b) Address Chesterfield, md
25. (a) 7/28/48 (b) L. J. Dalton
    (Date rec'd by registrar) (Registrar)
26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.
    Health Officer, per

* See Instruction C on stub.

V. S. A10

M

I

T

child Lived 10 minutes

RECEIVED
JUL 29 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160c 06906

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? One Minute

Hospital, institution, or street address where death occurred:

Annapolis Emergency Hospital

How long in hospital or institution? One Minute

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 935 Boucher Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Schofield

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Newborn

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 27, 1948

8. AGE: Years Newborn | Months | Days | If less than one day ..... hrs. One min.

9. Birthplace Annapolis Md (Town, County, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name John T. Schofield

13. Birthplace Elizabeth N.J.

MOTHER 14. Maiden name Mary V. Malloy

15. Birthplace N.Y. City

16. Informant John T. Schofield

Address Eastport Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 28th 1948 (month) (day) (year)

Cemetery or crematory St Mary's

Location Annapolis Md

18. Funeral director John M. Taylor Son

Address Annapolis Md

19. July 28 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1948 at 3:03 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Due to Atelectasis Prematurity	
Due to Premature Separating Placenta	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M.D. or other

Address Eastport Md Date signed 7/28/48

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JUL 30 1935
BUREAU V. S.

EVIDENCE FOR CHANGE OF AGE SHOWN ON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

306

06907

FILM No. G 116 JUL 23 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 26 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital,

How long in hospital or institution? 3 months, 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore County

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 139 Winters Drive

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: William Scott

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Colored	married

6.(b) Name of husband or wife: Estelle Scott

(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 1899?

8. AGE: Years	Months	Days	If less than one day
49 48 2.			hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER — 12. Name: —

13. Birthplace: —

MOTHER — 14. Maiden name: —

15. Birthplace: —

16. Informant: Hospital records

Address: Crownsville, Md.

17. Disposition: Burial Date thereof: 7/21/48

(Burial, cremation, or removal. Which?)

Cemetery or crematory: Maryland State

Location: A Cemetery Co.

18. Funeral director: A Halstead

Address: 918 Druid Hill Ave

19. July 19 48 Baltimore

(Date rec'd by registrar) A.W. Redwick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17, 1948 19 at 6 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22nd 1948 to July 17th 1948

and that I last saw him alive on July 17th 1948

	DURATION
Immediate cause of death: General paresis	Known to me since admission March 22nd 1948.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: — Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work?

23. SIGNATURE: Jacob Margenstern M. D.

M. D. or other

Address: — Date signed: —

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

Annapolis 2769 – 95C 016908

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M

1. PLACE OF DEATH:
County Anne Arundel
City or town c/o Wagner – Mega Site
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md – County Anne Arundel
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Florence Aller Seward

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Harry M. Seward
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 19 – 1888

8. AGE: Years	Months	Days	If less than one day
59	7	–	hrs. min.

9. Birthplace Richmond Hill-L.I. N.Y.
(Town, county, and state)
10. Usual occupation At Home
11. Industry or business

FATHER
12. Name Amos Aller
13. Birthplace Brooklyn N.Y.

MOTHER
14. Maiden name Catherine Lewis
15. Birthplace Farmington – Conn.

16. Informant Jane Seward Gatterus
Address 3212 Wallbrook Ave
17. Cremation (Burial, cremation, or removal. Which?) Date thereof July 21-48 (month) (day) (year)
Cemetery or crematory London Park
Location Baltimore Md.
18. Funeral director Ellsworth Annacost
Address 3911 Liberty Heights Ave
19. July 21 19 48 C. M. Wedert Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 July 1948 at 1:30 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 19 July 1948 to 19 July 1948
and that I last saw h alive on 19

Immediate cause of death	DURATION
Cardiac decompensation	4 hours
Due to Coronary occlusion	4 hours
Due to Arteriosclerosis	Approx. 5 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operation –
Date of op. –
Autopsy results –
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Thomas H. Hooker, M.D.
M. D. or other
Address 53 Cornhill St. Annapolis, Md. Date signed 21 July 48

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VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Salvans
Isaac

Sylvestre Salvans

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1318

06909

CERTIFICATE OF DEATH

Reg. Diat. No. 25

1. PLACE OF DEATH:

County A. A. Co.

City or town Brooklyn, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A. A. Co.

City or town Brooklyn, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4934 Brookwood Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George Thomas Snead

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Minnie J. Davis

6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) August 29, 1874

8. AGE:

Years	Months	Days	If less than one day
73			hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Federal Reserve Bank

11. Industry or business

FATHER

12. Name John Snead

13. Birthplace Maryland

MOTHER

14. Maiden name Jerimiah Buck

15. Birthplace Maryland

16. Informant Mrs Minnie J. Snead

Address 4934 Brookwood Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/24/48 (month) (day) (year)

Cemetery or crematory Loudon Park

Location Frederick Ave

18. Funeral director John T Kenney Inc

Address 915 Light St.

19. 7/24 1948 A.W. Hedrick Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21st 1948 at 12:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/1/48 1948 to 7/21 1948 and that I last saw him alive on July 20 1948

Immediate cause of death	DURATION
Chronic nephritis	
Due to senility	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel Rubin M.D.

M. D. or other

Address 203 Belvedere ave Date signed

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

184 06210

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH

County: Anne Arundel

City or town: Deale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Deale

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Deale Beach

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Jacqualine Spindle

3.(b) Social Security Number

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 1, 1934

8. AGE: Years: 13 Months: Days: If less than one day ..... hrs. ..... min.

9. Birthplace: Md. D. C.

(Town, county, and state)

10. Usual occupation: School

11. Industry or business

FATHER 12. Name: James P. Spindle

13. Birthplace: Loretto Virginia

MOTHER 14. Maiden name: Sally Roth

15. Birthplace: Russia

16. Informant: James P. Spindle

Address: Deale Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof 7/2/48 (month) (day) (year)

Cemetery or crematory: Peters Church

Location: Loretto Virginia

18. Funeral director: J. G. Saulsbury Funeral Home

Address: Galesville Md

19. 7/2 1948 (Date rec'd by registrar) M. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1 1948, at 7:20 A.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~

Postmortem Examination

~~and that I last saw him alive on~~ July 1 1948

	DURATION
Immediate cause of death	
Due to: Bullet wound in head entering left side of nose.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 7/1/48

Where did injury occur? Deale (City or town) Anne Arundel (County) Md (State)

Injured at home, farm, industry, public place (where?) at home

Means of injury: 22 Cal. rifle Injured at work? No

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner

Address: Annapolis, Md. Date signed: 7/2/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Loretto, Va

Fruit Spindle

Tappahannock

RECEIVED
JUL 3 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

06917 21

Reg. Diat. No.

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? dead on arrival
Hospital, Institution, or street address where death occurred: Emergency Hospital Annapolis Md
How long in hospital or Institution? dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: Balto Co.
City or town: 4202 Filtons Rd
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Baltimore
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME Charles Louis Steinwedel.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	widower

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 5. 1868

8. AGE:

Years	Months	Days	If less than one day
80	0	21	hrs. min.

9. Birthplace: Baltimore City, Maryland (Town, county, and state)
10. Usual occupation: Retired Captain
11. Industry or business: Fire Department

FATHER
12. Name: Charles Steinwedel
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Katherine Heiner
15. Birthplace: Baltimore, Maryland

16. Informant: Mrs. Lula Romoser (ROMOSER)
Address: 4202 Filtons Rd, Baltimore Md

17. Burial (Burial, cremation, or removal—which?) Date thereof 29 July 48 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore, Md.

18. Funeral director: H. B. Shipley & Son
Address: 800 Eutaw Place

19. 7/29/48 (Date rec'd by registrar) A W Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26 1948, at 5:45 P. M.

21. I CERTIFY that death occurred on the date above stated: ~~and that I last saw deceased alive on~~ Post mortem Examination July 26 1948

Immediate cause of death	DURATION
Asthenia - Selerotic Heart Disease	unknown
Due to: Chronic Myocarditis	unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Caffy MD Deputy Medical Examiner
M. D. or other
Address: Annapolis, Maryland Date signed: 7-26-48

VS-A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46 b

C6912

Reg. Diat. No. 26

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Linthicum Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs

Hospital, Institution, or street address where death occurred: Patapsco

How long in hospital or Institution? 1

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Anne Arundel

City or town: Linthicum Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No. Patapsco

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: James Bradford Thomas

3.(b) Social Security Number: 717-07-6538

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	married

6.(b) Name of husband or wife: Lucia Thomas

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): May 4 1880

8. AGE: Years: 68 Months: 2 Days: 8 If less than one day: ____ hrs. ____ min.

9. Birthplace: Charles Co. Md (Town, county, and state)

10. Usual occupation: Laborer Farm Gen.

11. Industry or business: Retired

FATHER — 12. Name: Samuel Thomas

FATHER — 13. Birthplace: Charles Co Md

MOTHER — 14. Maiden name: Julia Ann Green

MOTHER — 15. Birthplace: Chas Co. Md

16. Interment: Lucia Thomas Lady

Address: Box 46A Linthicum Heights Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-14-48 (month) (day) (year)

Cemetery or crematory: St Augustine Cem

Location: [illegible]

18. Funeral director: W. A. Hillhead

Address: 918 Druid Hill Ave

19. 7-13 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 12 1948, at 8 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1947, to July 12 1948

and that I last saw h[illegible] alive on July 12 1948

Immediate cause of death	DURATION
Carcinoma of Stomach	2 yrs
* Cerebral Hemorrhage	6 hrs
Due to:	
Myocardial Insufficiency	2 mos
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: cancer of stomach

Date of op. July 4 48

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: B B Bramble Jr M. D. or other

Address: Elkridge Md Date signed 7/12/48

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

069134 C

Reg. Dist. No.

1. PLACE OF DEATH Owensville, A.A. Co.

County

City or town Owensville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A.A.

City or town Owensville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sarah Lillian Tucker

3.(b) Social Security Number

4. Sex F

5. Color or race W

6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife Charles Thomas Tucker

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1870

8. AGE: Years 77 Months 7 Days 15 If less than one day hrs. min.

9. Birthplace Calvert Co.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Dove

13. Birthplace

MOTHER 14. Maiden name Eliza Ellen Dove

15. Birthplace Calvert Co. Md.

16. Informant Daisy T. Suitt

Address Owensville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/2/48 (month) (day) (year)

Cemetery or crematory Friendship Methodist

Location Friendship, Md.

18. Funeral director T.A. Hardesty & Son

Address Galesville, Md.

19. 8/2/48 (Date rec'd by registrar) 19 M.P. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 19 48 at 9.25 A.M.

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from July 23 19 48 to July 29 19 48 and that I last saw h... alive on July 29 19 48

	DURATION
Immediate cause of death Coronary occlusion	
Due to Coronary disease	
Due to arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Emily H. Wilson, M.D. M. D. or other

Address Lothian, Md. Date signed 7/31/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS A15 9-45-15

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RECEIVED
AUG 3 1948
BUREAU V. S.

STATE

BALTIMORE ~~CITY~~ HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 06914 21

1. PLACE OF DEATH:
(a) ~~Baltimore City, Maryland~~ Glen Burnie, Md.
(b) Street address 2nd & Crain. Md.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in ~~Baltimore~~ (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Glen Burnie.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Second Ave & Crain.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Elizabeth L. Walter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Henry M. Walter
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Dec 20 1898

8. AGE: Years	Months	Days	If less than one day
49	6	6	____ hr. ____ min.

9. Birthplace Harford Co, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Lloyd
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Mary Singleton
15. Birthplace Harford Co Md

16 (a) Informant Ellen C. Lloyd
(b) Address 3316 Ellerslie Ave

17 (a) Removal (b) Date thereof 7-13-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Slate Ridge.
Location Delta, Pa.

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Pl

19 (a) 7/13 (b) 48 L.J. Healy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/13 1948, at 6-5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1948 to July 12 1948, and that I last saw her alive on 7/12 1948.

Immediate cause of death	Duration
Pulmonary Tuberculosis	16 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. M. J. Healy M. D.
Address 2426 Eutaw Pl Date signed 7/13/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

VS 150

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

06915 Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 hours
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: 52 Calvert St
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Annapolis
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Maggie L. Walton

3. (b) Social Security Number: Denied 2 R.M.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife: Thomas Walton
6.(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Sept 29. 1883

8. AGE:

Years	Months	Days	If less than one day
64	9	21	____ hrs. ____ min.

9. Birthplace: Cal Co (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: William Marquess
13. Birthplace: Cal.
MOTHER 14. Maiden name: A. Yates
15. Birthplace: Cal Co
16. Informant: Thomas Walton
Address: 52 Calvert St Annapolis
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 21 1948 (month) (day) (year)
Cemetery or ~~crematory~~: Cemetery
Location: Annapolis Anne.
18. Funeral director: F. C. Hardesty & Son
Address: Galesville Md.
19. July 19 1948 (Date rec'd by registrar) Wm. J. Brunch Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18 1948 at ~~4:40~~ 4:40 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1947 to July 18 1948
and that I last saw h[illegible] alive on July 18 1948

Immediate cause of death	DURATION
Coronary Thrombosis	1 Day
Due to Arteriosclerosis	1 Yr.
Due to Coronary Sclerosis	unknown
Due to	
Other conditions Cataract Senile Incised	unknown

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George C. Bond M. D. or other
Address: Annapolis Md. Date signed 7-18-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

RECEIVED
JUL 20 1948
BUREAU V. S.

VS A15 9-45 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06916

183

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH:
County: A. A.
City or town: Severn River
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 519 Burnside Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Francis Joseph Wanex
3.(b) Social Security Number:

4. Sex: Male
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife:
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Nov 26th 1929
8. AGE: Years 18 Months 7 Days 30 If less than one day ... hrs. ... min.
9. Birthplace: Baltimore Md.
(Town, county, and state)
10. Usual occupation: Clerk at A & P. Store
11. Industry or business: Annapolis Md.
FATHER 12. Name: Frank J. Wanex
13. Birthplace: Maryland
MOTHER 14. Maiden name: Margaret Rozicka
15. Birthplace: Baltimore
16. Informant: Frank J. Wanex
Address: 519 Burnside Ave. Eastport Md.
17. Burial Date thereof: July 29th 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: St Marys
Location: Annapolis Md.
18. Funeral director: John M. Taylor Son
Address: Annapolis Md
19. July 28 1948 Wm. [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 25 1948, at about 9[15] P. M.
21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Postmortem Examination ~~and that I last saw h... alive on~~ July 27 1948

Immediate cause of death: Drowning

	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: ... Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accidental Date of: 7-25-48
Where did injury occur? near Winchester Anne Arundel Maryland
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Severn River
Means of injury: Drowning Injured at work? no
23. SIGNATURE: John M. Claffy, M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Maryland Date signed: 7-28-48

RECEIVED
JUL 30 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1336

06917

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: A. A.

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hospt

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A.

City or town: Severna Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lillie B. Way

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John Way

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 20th 1890

8. AGE: Years	Months	Days	If less than one day
57	10	2	..... hrs. ..... min.

9. Birthplace: Penn. (Town, county, and state)

10. Usual occupation: Home wife

11. Industry or business

FATHER

12. Name: James Brown

13. Birthplace: Penn.

MOTHER

14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: John Way

Address: Severna Park R.F.D. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 24th 1948 (month) (day) (year)

Cemetery or crematory: Glen Haven Memorial

Location: Glen Burnie Md.

18. Funeral director: John M. Gay & Son

Address: Annapolis Md.

19. July 24 1948 (Date rec'd by registrar) M. D. Brush Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22 1948 at 1:10 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 19 1948 to July 22 1948 and that I last saw h[illegible] alive on July 21, 1948

Immediate cause of death	DURATION
Due to: (a) Pyelonephritis (b) Pericnephritic abscess	9 days
Due to: old bilateral kidney	yrs.
Other conditions: Crippled & distorted c multiple arthritis	yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: M. F. Klavans Md

M. D. or other

Address: Annapolis Md. Date signed: 7/22/48

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 27 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

48 b 06918 21

Reg. Diat. No.

1. PLACE OF DEATH:

County ANNE ARUNDEL

City or town RIVIERA BEACH

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County ANNE ARUNDEL

City or town RIVIERA BEACH

(If outside city or town limits, write RURAL and give nearest town)

Street No. HARLEM RD

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME BESSIE M WEIBE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	WHITE	MARRIED

6.(b) Name of husband or wife OTTO WEIBE SR 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 25, 1888

8. AGE: Years	Months	Days	If less than one day
60			hrs. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation H.W

11. Industry or business

FATHER 12. Name GEORGE CARSON

13. Birthplace MD

MOTHER 14. Maiden name LILLIAN PERRY

15. Birthplace MD

16. Informant MR OTTO WEIBE JR

Address HARLEM RD RIVIERA BEACH

17. BURIAL. Date thereof JULY 27 '48 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory LOUDON PARK

Location 3801 EDMUNDSON AVE

18. Funeral director Henry H Wilson

Address 4104 EDMONDSON AVE

19. 7/26 19 48 A.W. Helbert Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 23 19 48 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 48, to July 23 19 48 and that I last saw h her alive on July 23 19 48

Immediate cause of death Carcinoma of uterus — DURATION Cont

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE Thos H Phillips M. D. or other

Address 3307 Edmondson Ave Date signed: 7-26-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1948
60

1888

STATE OF MARYLAND—CERTIFICATE OF DEATH 06919

131a

1. PLACE OF DEATH

County Anne Arundel Co Registration Dist. No. 21

Village or City Near Severna Park No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U.S. if of foreign birth? — yrs. — mos. — ds.

2. FULL NAME Harold Edward West If U. S. Veteran, specify WAR —

(a) Residence: No. Severna Park, Md St., — Ward. —

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male.	White.	Widowed.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Maud West.

6. DATE OF BIRTH (month, day, and year) Nov. 14, 1866

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
81	8	10	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Public Service Comm. & Reporter

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. News Paper —

10. Data deceased last worked at this occupation (month and year) 1945

11. Total time (years) spent in this occupation Over 40 yrs

12. BIRTHPLACE (city or town) Baltimore Md. (State or country)

FATHER

13. NAME Geo. F. West

14. BIRTHPLACE (city or town) Virginia. (State or country)

MOTHER

15. MAIDEN NAME Mary Diana Williams

16. BIRTHPLACE (city or town) Virginia (State or country)

17. INFORMANT William West. (Address) Severna Pk Md.

18. BURIAL, CREMATION, OR REMOVAL Place Westlawn, Severn Pk Md Date July 27, 1945

19. UNDERTAKER Wm. Tarkan & Sons (Address) Balto. Md.

20. FILED 7/26, 1945 Alv Hedrick Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH July (Month) 24 (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from June 10, 1945, to July 24, 1945.

I last saw h— alive on July 24, 1945; death is said to have occurred on the date stated above, at 4:05 P. m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Chronic Valvular Disease of the Heart	2 years
Other **Contributory Causes** of importance: Chronic Interstitial Nephritis & Hypertension	5 yrs

Name of operation None Date of

What test confirmed diagnosis? Symptoms Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Jane S. Billingsley M. D.

(Address) Glen Burnie Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

06920

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 1 mo. 19 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 1 yr. 1 mo. 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: ---

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1039 Harlem Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3.(a) FULL NAME: JENNIE WHITFIELD

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	negro	single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1885

8. AGE: Years: 63 | Months: | Days: | If less than one day: ... hrs. ... min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: unknown

11. Industry or business: ---

FATHER — 12. Name: unknown

13. Birthplace: -----

MOTHER — 14. Maiden name: unknown

15. Birthplace: -----

16. Informant: Hospital Records

Address: Crownsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 20 1948 (month) (day) (year)

Cemetery or crematory: Mt. Auburn Cem.

Location: mt. Winan. Balto. Md.

18. Funeral director: Mrs. Samuel T. Kemp

Address: 578 W. Biddle St.

19. 7-16 48 (Date rec'd by registrar) E.T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15 19 48 at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26 19 47 to July 15 19 48 and that I last saw h...er alive on July 15 19 48

	DURATION
Immediate cause of death: Chronic Myocarditis	
known to us since	5/26/47
Due to:	
Due to:	
Other conditions: Senile Dementia	
known to us since	5/26/47

(Include pregnancy within 3 months of death)

Major findings of operations: ---

--- Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ----- Date of ...

Where did injury occur? ---- (City or town) --- (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: --- Injured at work?

23. SIGNATURE: Jacob Montgomery M.D. M. D. or other

Address: Crownsville, Md. Date signed 7/15/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

RECEIVED
JUL 19 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a 06921

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Davidsonville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 yrs

Hospital, institution, or street address where death occurred:

Central Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Davidsonville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Hy-way Rt. #214

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: BERNARD H. WILLIAMS, Sr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Martha D. Williams

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): October 27, 1887

8. AGE: Years	Months	Days	If less than one day
60 (60-8-5)	8	5	..... hrs. ..... min.

9. Birthplace: Davidsonville, A.A. Co., Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farming

FATHER

12. Name: John I. Williams

13. Birthplace: Maryland

MOTHER

14. Maiden name: Sally M. Hodges

15. Birthplace: Maryland

16. Informant: Mr. Bernard H. Williams Jr.

Address: Central Ave. Davidsonville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 4, 1948 (month) (day) (year)

Cemetery or crematory: All Hallows Cemetery

Location: Davidsonville, Maryland

18. Funeral director: Ben L. Hopping and Son

Address: 170-172 West St. Annapolis, Maryland

19. ..... 19..... (Date rec'd by registrar) Carrie J. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2 1948, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 29 1948, to July 2 1948 and that I last saw him alive on July 1 1948

Immediate cause of death	DURATION
Coronary occlusion	
Due to: Coronary disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Emily N. Wilson, M.D. M. D. or other

Address: Lothian, Md. Date signed 7/3, 48

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

RECEIVED
SEP 9 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159 06922

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 Minutes
Hospital, Institution, or street address where death occurred:
U.S. Naval Hospital, Annapolis, Maryland
How long in hospital or institution? 35 Minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 701 Dreams Landing
(If rural, give LOCATION)
2.(a) If veteran, name war: --

3.(a) FULL NAME: BRENT THOMAS WILLIAMS

3.(b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White-US	Single

6.(b) Name of husband or wife: --
6.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): July 31, 1948

8. AGE:

Years	Months	Days	If less than one day
0	0	0	0 hrs. 35 min.

9. Birthplace: Annapolis, Anne Arundel, Maryland
(Town, county, and state)

10. Usual occupation: --

11. Industry or business: --

FATHER
12. Name: John E. Williams
13. Birthplace: Camden, New Jersey

MOTHER
14. Maiden name: Patricia Louise Barnes
15. Birthplace: Elkhorn, Wisconsin

16. Informant: John E. Williams
Address: 701 Dreams Landing, Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8-2-48 (month) (day) (year)
Cemetery or crematory: Naval Cemetery
Location: Annapolis, Maryland

19. Funeral director: B.L. HOPPING AND SON
Address: 172 West St., Annapolis, Maryland

19. August 2 19 48 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 31 July 19 48, at 9:35a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9:00am 7-31 19 48, to 9:35a.m. 7-31 19 48
and that I last saw him alive on 31 July 19 48

Immediate cause of death: Pre-mature - 26wks gestation - Weight 2# lbs. — DURATION: 35 mins.
Due to: --
Due to: --
Other conditions: --
(Include pregnancy within 3 months of death)

Major findings of operations: -- Date of op.: --
Autopsy results: --
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work? --

23. SIGNATURE: JESSE W. MILLER, Captain MC USN (M. D. or other)
Address: U.S.N.H., Annapolis, Md. Date signed: 7-31-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
AUG 3 1948
BUREAU V. S.

Dr Basil

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

06923

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A.

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Carvel Hall Hotel Pro Geo St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Elizabeth Deakins Wilson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Divorced

6.(b) Name of husband or wife: Sidney Sladden

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 28th 1882

8. AGE: Years	Months	Days	If less than one day
65	8	0	hrs. min.

9. Birthplace: Georgetown D. C.

(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: William Alex Wilson

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Florence Serpell

15. Birthplace: Maryland

16. Informant: Mrs Florence Wilson Serpell

Address: 374 Woodland Place S. Orange N. J.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 30th 1948 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis Md.

18. Funeral director: John M. Taylor Son

Address: Annapolis Md.

19. July 30 1948 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 1948 at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24 1948 to July 28 1948 and that I last saw h.. alive on July 28 1948

	DURATION
Immediate cause of death: Myocarditis Chr.	Several
Due to: Hypertension Emphysema	years
Due to: Arteriosclerosis	several years
Due to: Bronchial Asthma	years
Other conditions: Bronchitis	several years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Geo C Boyd M. D. or other

Address: Annapolis Md. Date signed: 7-31-48

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
AUG 3 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

06924

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 422 Third St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Annie M. Wisenauer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John C. Wisenauer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar 31st 1878

8. AGE: Years: 70 | Months: 3 | Days: 18 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual occupation: Ret painter U.S. Navy

11. Industry or business: Academy

FATHER

12. Name: Martin Beck

13. Birthplace: Germany

MOTHER

14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: John C. Wisenauer

Address: 422 Third St. Eastport Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 22nd 1948 (month) (day) (year)

Cemetery or crematory: Glen Haven Memorial

Location: Glen Burnie Md.

18. Funeral director: Howard Evans

Address: 1400 S. Charles St Balto Md.

19. July 18 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17 1948, at 2:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 12 1948 to July 17 1948 and that I last saw h.. alive on July 16 1948

	DURATION
Immediate cause of death: Coronary occlusion	1/4 hr.
Due to: hypertensive cardio-vascular disease	15 yr.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury ..... Injured at work?

23. SIGNATURE: S. Bozzuto M.D. M. D. or other

Address: Annapolis Md Date signed: 7/18/48

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUL 23 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

016925

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? dead on arrival
Hospital, institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State District of Columbia County D.C.
City or town Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3814 Davis Place N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Gertrude V. Woolley

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife —
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Feb. 22nd 1888
8. AGE: Years 60 Months 4 Days 12 If less than one day ... hrs. ... min.
9. Birthplace New York City, N.Y. (town, county, and state)
10. Usual occupation Housewife
11. Industry or business —

FATHER
12. Name Wm Vail
13. Birthplace New York City

MOTHER
14. Maiden name Cecelia Drew
15. Birthplace New York City

16. Informant Mrs. Edgar R. Hill
Address 3814 Davis Place, Wash. D.C.
17. Removal (Burial, cremation, or removal. Which?) Date thereof July 5, 1948 (month) (day) (year)
Cemetery or crematory Joseph Gawler's Sons
Location 1750-58 Pennsylvania Ave N.W. Wash. D.C.
18. Funeral director Joseph Gawler's Sons Wash. D.C.
Address 1750-58 Penn. Ave N.W. Wash. D.C.
19. July 5 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1948, at 2:55 P.M.
21. I CERTIFY that death occurred on the date above stated: ~~to the best of my knowledge from~~ Postmortem Examination from July 5 1948
~~and that I last saw him alive on~~

Immediate cause of death — DURATION
Coronary Occlusion
Due to
Coronary sclerosis
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John M. Caffey M.D., deputy medical examiner
M. D. or other
Address Annapolis, Md. Date signed 7-5-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

RECEIVED
JUL 7 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

06926

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MD. County: Wic.

City or town: SHARPTOWN

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: No ✓

3.(a) FULL NAME: Georgia A. Wright.

3.(b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	WIDOW

6.(b) Name of husband or wife: JOHN WRIGHT

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): JAN. 30, 1871

8. AGE: Years	Months	Days	If less than one day
77	5	11	..... hrs. ..... min.

9. Birthplace: GLOUCESTER Co., Va. (Town, county, and state)

10. Usual occupation: HOUSEWIFE

11. Industry or business: —

FATHER — 12. Name: BENJAMIN PRATT

13. Birthplace: PHILA, Pa.

MOTHER — 14. Maiden name: UNKNOWN

15. Birthplace: "

16. Informant: MR. BENJAMIN H. PRATT (NEPHEW)

Address: 3103 MARECO AVE-13

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 7/14/48 (month) (day) (year)

Cemetery or ~~cemetery~~: LORRAINE CEM.

Location: BALTO. MD.

18. Funeral director: WM. T. TICKNER & SON

Address: BALTO. MD.

19. 7/13/48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11 19 48 at 9⁰⁰ P. M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from June 10 19 48 to July 11 19 48 and that I last saw h[illegible] alive on July 11 19 48

Immediate cause of death	DURATION
Cerebral hemorrhage	3 days
Due to: Hypertensive arteriosclerotic	
Due to: Cardiovascular disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: L. Peyton Ritchings, M.D. (M. D. or other)

Address: Annapolis, Md. Date signed: July 11, 1948

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING